

Hang-out time of pulmonary valve in d-transposition of great arteries

Sir,

I note that in the March issue of the *British Heart Journal* Dr Fouron and his colleagues once more used the term "d-transposition of the great arteries". I have written previously expressing concern at the possible misuse of this term, but from the fact that Dr Fouron and his colleagues continue to use it, and also from discussions and correspondence with many colleagues, I know that my previous letter failed to express adequately the point I was trying to make. There is nothing wrong with the term "d-transposition" when it is used to describe a heart with the aorta arising from a morphologically right ventricular chamber, the aortic valve being to the right of the pulmonary valve. This is the fashion in which, as Dr Fouron and his colleagues pointed out in their response to my previous letter, the term is used by Dr Van Praagh and his colleagues. In their previous letter Dr Fouron and his colleagues went on to say that complete transposition was a physiological designation. I would submit that their present article describes exactly such a physiological situation. If I understand their article correctly, they are not describing results pertinent to all patients who might have a right-sided aorta arising from a morphologically right ventricle. This of course could include patients with tricuspid atresia and transposition, patients with double inlet ventricle and transposition, and even some patients with physiologically corrected transposition in situs inversus. I do not believe that it is the intention of the Montreal group to imply that their results are applicable to all these patients, who could correctly be stated as having "d-transposition". What I believe the Montreal group are describing are findings pertinent to patients having complete transposition. Indeed, throughout the rest of their paper they simply use the term "transposition of the great arteries". My previous letter gave considerable scope for misinterpretation. Indeed, I know from correspondence that it was widely misinterpreted. All I was trying to say was that, for the patients described by Dr Fouron and his colleagues, "complete transposition" is a scientifically accurate and appropriate term. "d-transposition" may apply to the majority of the

patients, but it does not describe all of them, and certainly describes many patients who do not fall within the group described by the Montreal investigators. I therefore stand by my earlier contention that, for the overall group of patients—patients with atrioventricular concordance and ventriculoarterial discordance—complete transposition is a more appropriate term than "d-transposition".

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This letter was shown Dr Fouron and his colleagues who reply as follows.

Sir,

In his letter, Professor R H Anderson deplores once again the use of d-transposition (d-TGV) in our article on "Hang-out time of pulmonary valve in d-transposition of great arteries".¹ We agree with Professor Anderson that d-TGA means cases of TGA in which the aortic valve lies to the right (dextro or D) relative to the pulmonary valve. When d-TGA is used without further qualification, however, the typical situation, that is TGA {S, D, D}, (TGA with situs solitus and D-loop) is meant as in all patients in our series and as in 95% of necropsied cases. Hence d-TGA is convenient shorthand. When other malformations are present they must be mentioned, as for instance tricuspid atresia with d-TGA. Patients with physiologically corrected transposition in situs inversus should be described as having situs inversus (I), ventricular D-loop (D), and d-transposition of the great arteries (D), or simply {I, D, D}. We believe that anatomical precision is important physiologically

Correspondence

and surgically. The segmental approach to the diagnosis of congenital heart disease applies accurately in all anomalies, no matter how complex.

Reference

- 1 Fourn JC, Douste-Blazy MY, Ducharme G, van Doesburg N, Davignon A. Hang-out time of pulmonary valve in d-transposition of great arteries. *Br Heart J* 1982;47:277-80.

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This correspondence is now closed. Ed.